Recommendations of the Maternal Mortality Review Stakeholder Group

Additions to the recommendations in the Maternal Mortality Review 2018 Annual Report:

- Screen for behavioral health risks (substance use disorder, mental health, intimate partner violence) at least every trimester during pregnancy and postpartum, or ideally at every visit. Screening, especially for intimate partner violence, should be done in private.
- Increase provider awareness of the interrelatedness of these behavioral health risks. If a pregnant woman screens positive for any one risk, the others should be screened for.
- Include screening for social determinants of health in each screening, including access to safe housing, food, transportation, and utility services.
- Expand the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) program to include screening and referral for perinatal mental health disorders. This could be accomplished either by providing maternal screening at pediatric visits, or by developing a parallel program of mental health consultation and support for obstetricians caring for pregnant and postpartum women.
- Include intimate partner violence screening in pediatric visits.
- Dedicate a portion of the federal funding received by Maryland for opioid use disorder and its related behavioral health issues specifically to the treatment of pregnant and postpartum women.

Recommendations to improve maternal care and reduce maternal morbidity and mortality:

- Increase health care provider awareness and adoption of the American College of Obstetricians and Gynecologists (ACOG) recommendations for optimizing postpartum care as outlined in the May 2018 ACOG Committee Opinion statement.
- Improve completion of the Maryland Medicaid Pregnancy Risk Assessment (PRA) form. Make the form electronic statewide for ease of completion and to allow data analysis.
- Conduct internal reviews of cases of severe maternal morbidity at each delivery hospital to evaluate quality of care, adherence to established guidelines, and opportunities for prevention.
- Review preventability of the leading causes of maternal death to identify what factors most commonly were identified that potentially could have prevented the death to better direct patient education and disease prevention efforts as well as to enhance the quality of care provided.

Recommendations to address disparities in maternal mortality:

- Assure that the team conducting maternal mortality reviews is diverse (race, ethnicity, gender, professional field, geographic representation, etc.) and includes representation of community groups that directly serve the communities most affected by poor maternal health outcomes, including Black and Latina women and low-income women and their families.
- Include community groups addressing intimate partner violence prevention and support in the review process.

- Include data on maternal insurance coverage (Medicaid vs. private insurance) for maternal death cases.
- Investigate risk factors, such as pre-existing medical conditions and social risk factors, by race among maternal death cases.
- Evaluate data on hemorrhage deaths, including geographic information on site of care.
- Evaluate birth outcomes, severe maternal morbidity, adherence to clinical guidelines, quality metrics and patient satisfaction data by racial stratification at each delivery hospital.